Helping You Become a Better You.

THE SCHOOL DISTRICT OF CLAYTON

2018 Employee Benefits Guide

Non-Discrimination Disclosure

It is the policy of the School District of Clayton not to discriminate on the basis of race, color, religion, gender, national origin, age, or disability in its programs or employment practices as required by Title VI and VII of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975 and Title II of the Americans with Disabilities Act of 1990.

Behavior that is not unlawful or does not rise to the level of illegal discrimination or harassment might be unacceptable for the workplace or the educational environment. Demeaning or otherwise harmful actions are prohibited, particularly if directed at personal characteristics. Accordingly, the District prohibits discrimination or harassment on the basis of sexual orientation, perceived sexual orientation or gender identity.

Inquiries related to the District's employment practices should be directed to Dr. Tim Dilg, School District of Clayton, #2 Mark Twain Circle, Clayton, Missouri 63105 or by phone at (314) 854-6012. Inquiries related to the District's student programs should be directed to Dr. Kashina Bell, Assistant Superintendent of Student Services, School District of Clayton, #2 Mark Twain Circle, Clayton, Missouri, 63105 or by phone at (314) 854-6013.

Inquiries or concerns regarding civil rights compliance by school districts should be directed to the local school district Title IX/non-discrimination coordinator. Inquiries and complaints may also be directed to the Kansas City Office, Office for Civil Rights, US Department of Education, 8930 Ward Parkway, Suite 2037, Kansas City, MO 64114; (816) 268-0550; TDD (877) 521-2172.

School District of Clayton

#2 Mark Twain Circle

Clayton, Missouri 63105

(314) 854-6000

The purpose of this booklet is to describe the highlights of your benefit program. Your specific rights to benefits under the Plans are governed solely, and in every respect, by the official Plan documents and insurance contracts, and not by this booklet. If there is any discrepancy between the description of the Plans as described in this material and official Plan documents, the language of the documents shall govern.

2018 Benefits Guide

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R.M. CAPTAIN ELEMENTARY SCHOOL
THE FAMILY CENTER

The School District of Clayton, in partnership with the following carriers, strives to meet your benefit needs. If you have any questions regarding your benefits, please contact the corresponding carrier listed below or the business office.

Contacts

COVERAGE	VENDOR	PHONE NUMBER	WEBSITE
MEDICAL	Anthem Policy Number: 00188724	800.490.6145	anthem.com
DENTAL - PPO	MetLife Policy Number: 5912372	800.438.6388	MetLife.com
DENTAL - DHMO	Cigna Policy Number: 10050105	800.244.6224	cigna.com
VISION	Vision Benefits of America Policy Number: 776	800.432.4966 For Lasic Savings: 877.437.6105	visionbenefits.com
Health Savings Account (HSA)	BenefitWallet Policy Number: None	877.472.4200	mybenefitwallet.com
LIFE / AD&D **VOLUNTARY LIFE / AD&D** **LONG-TERM DISABILITY**	MetLife Policy Number: 5912372	800.438.6388	MetLife.com
EMPLOYEE ASSISTANCE PRO-GRAM (EAP)	Personal Assistance Services Policy Number: None	800.356.0845	paseap.com
FLEXIBLE SPENDING ACCOUNT (FSA)	CBIZ Flex Policy Number: None	800.815.3023 Fax: 800.584.4185	myplans.cbiz.com

BENEFITS TEAM		PHONE NUMBER	EMAIL
Donna Clifton Eric File	CBIZ	314.692.2249 314.692.5848	dclifton@cbiz.com efile@cbiz.com
Shane Hurst Financial Advisor	VALIC Financial Advisors, Inc.	314.439.4850 Office 314.704.4888 Cell	shane.hurst@valic.com
Barb Daves - Benefits Linda Benz - Payroll	School District of Clayton	314.854.6024 314.854.6029	barbdaves@claytonschools.net lindabenz@claytonschools.net

Understanding Your Plan Options

As an employee of the School District of Clayton, you are offered an employee benefit package that includes Medical, Dental, Vision, Basic Life / Accidental Death & Dismemberment (AD&D), Supplemental Life / Accidental Death & Dismemberment, Long-Term Disability (LTD), and Long-Term Care.

The District's medical coverage will continue to be provided through Anthem using their Blue Access/Blue Choice PPO network . You are offered the choice of three options, Base Plan, Buy-Up Plan, and a Qualified High Deductible Plan (QHDHP) which includes a Health Savings Account (HSA). If you elect the QHDHP, the District contributes from the allotment, $125 per month into your HSA.

The dental plan offers two options. The first is a Preferred Provider Organization (PPO) through MetLife. This option allows you to move freely between in-network and non-network providers. The second option is a Dental Health Maintenance Organization (DHMO) through Cigna. This type of plan offers a greater benefit; however, it is more restrictive as you must choose a network provider for your dental care. The list of available dentists is limited and you must be on the dentist's eligibility roster to receive services. You will receive all dental services from your elected provider and must be referred to a specialist for any special dental procedures.

The District offers one vision plan through Vision Benefits of America. The vision plan offers a network of providers where you will receive the best benefit. If you go out -of-network for services, you will receive a limited reimbursement.

Basic Life / AD&D and Long -Term Disability are offered to eligible employees at no cost. Supplemental Life / AD&D and Long -Term Care are offered as voluntary benefits.

The District offers eligible employees an allotment to pay for the employee cost of the Anthem Base Medical Plan, the MetLife PPO Dental, and the Vision Benefits of America Vision plan. The 2018 total allotment is $684.07 per month per eligible employee to pay for elected employee coverage.

The District offers an $1,800 stipend to any employee who elects to waive their medical coverage. The stipend is divided equally over the course of the plan year on each pay date. You must be eligible for the medical insurance benefit and prove you are covered elsewhere. A signed waiver is required and the stipend is paid as taxable income.

This Benefit Guide provides a brief summary of all the District's benefit plans along with the rates based upon the coverage you select. You will also find notices and other important information in this guide.

ENROLLING IN THE PLANS

ENROLLING IN THE PLANS IS FAST AND EASY - HERE'S HOW:

- Read your materials and make sure you understand all of the options available.
- Before you begin, be prepared with the Social Security Numbers and Dates of Birth for all dependents and beneficiaries.
- Login to the Employee Portal:
  https://emport.claytonschools.net/keynet/
- Locate the CBIZ Enrollment Site
  User ID: First initial of First and Last name plus the last 4 digits of your Social Security Number. (dc5678)
  Password: Date of Birth (mmddyyyy)

  You can also access the enrollment site outside the employee portal at **cbizesc.com/clayton** or call 1800-844-4510; ext 140, 148 or 134
- On the main menu under "enroll/change your benefits", click "Plan Year Beginning January 1, 2018"
- Follow the onscreen instructions to complete your enrollment.
- Review your elections and if correct click "Confirm"
- Print and Save your confirmation number.

IMPORTANT NOTE:

It is very important that you complete your enrollment by the due date provided by the Business Office. If you do not complete your enrollment by the due date, you risk losing your opportunity to elect a plan of your choice.

ELIGIBILITY

The Board defines a benefit eligible full-time employee as a staff member the District reasonably expects to work an average of 30 hours or more per week.

Eligible employees who are hired on a full-time basis, and the letter of employment or contract start date is the first day of the month, are eligible for coverage on this date. All other full-time employees are eligible for coverage on the first day of the following month.

If you qualify as a benefit eligible full-time employee as described above you may elect to enroll yourself and your eligible dependents in our medical, dental, vision, and voluntary life benefits. You are automatically enrolled for the District's Base Life / Accidental Death & Dismemberment, and Long -Term Disability.

WHO CAN YOU ADD TO YOUR PLAN:

Eligible:

- **Legal spouse**
- **Natural and adopted children up to age 26**
- **Your stepchildren**
- **Children placed in your custody for adoption**
- **Children under your legal guardianship**
- **Children under a qualified medical child support order**
- **Disabled children 26 years or older**

Ineligible:

- **Divorced or legally separated spouse**
- **Common law spouse**
- **Domestic partner**
- **Children of Domestic partner unless employee has adopted or been granted legal guardianship.**
- **Foster children**
- **Sisters, brothers, parents, or in-laws,**

FREQUENTLY ASKED QUESTIONS

ARE CHANGES TO MY PLAN ALLOWED DURING THE YEAR?

Generally, you may only enroll in the plan, or make changes to your benefits, during the open enrollment period or when you are first hired. However, you can make changes/enroll during the plan year if you experience a qualifying event. As with a new enrollee, you must have your paperwork turned in within 31 days of the qualifying event or you will have to wait until the next annual open enrollment period. Premiums and enrollment eligibility may change; contact Barb Daves at (314) 854-6024 in the Business Office for details.

EXAMPLES OF QUALIFYING EVENTS?

- You or your dependents lose health coverage because of loss of eligibility or loss of employer contributions
- You get married, divorced, or legally separated (with court order)
- You have a baby or adopt a child
- You or your spouse take an unpaid leave of absence
- You or your spouse dies
- You become eligible for or lose other coverage
- Medicaid coverage
- You become eligible for Medicare

WANT TO KNOW WHAT MEDICARE COVERS?

GO ON-LINE TO FIND OUT!

Here is how you do it…

Go to **medicare.gov**

1. Go to the top of the page, on the tool bar go to “What Medicare Covers”.
2. Under “What Medicare Covers” click on “Your Medicare Coverage”.
3. In the dialog box, enter what medical care you are needing to determine if covered.
4. Click on “Go” after you have entered the information.
5. View results.

OR YOU MAY CALL MEDICARE WITH YOUR QUESTIONS:

1-800-633-4227

School District of Clayton

MEDICAL - ANTHEM

Traditional PPO Plans

BASE PLAN

Benefit/Service	In Network	Non-Network
Deductible	$750 / Individual $1,500 / Family	$1,500 / Individual $3,000 / Family
Coinsurance	90%	60%
Out-of-Pocket Maximum	$3,500 / Individual $7,000 / Family	$6,000 / Individual $12,000 / Family
Office Visit	$30 Primary Care $60 Specialist	60% After Deductible
Preventive Care	100% Covered	60% After Deductible
Inpatient/Outpatient Hospital Services	90% After Deductible	60% After Deductible
Urgent Care	$50 Co-Pay	60% After Deductible
Emergency Room	$300 Co-Pay	$300 Co-Pay
Prescription Drug Co-Pay	Tier 1 / Tier 2 / Tier 3 $10 / $40 / $70	Not Covered
Mail Order Co-Pay	$20 / $80 / $140	Not Covered

The School District of Clayton contributes the employee cost of the Base Plan to the annual allotment.

BUY-UP PLAN

Benefit/Service	In Network	Non-Network
Deductible	$250/ Individual $500 / Family	$500/ Individual $1,000 / Family
Coinsurance	100%	70%
Out-of-Pocket Maximum	$2,500 / Individual $5,000 / Family	$4,000 / Individual $8,000 / Family
Office Visit	$25 Primary Care $50 Specialist	70% After Deductible
Preventive Care	100% Covered	70% After Deductible
Inpatient/Outpatient Hospital Services	100%	70% After Deductible
Urgent Care	$50 Co-Pay	70% After Deductible
Emergency Room	$200 Co-Pay	$200 Co-Pay
Prescription Drug Co-Pay	Tier 1 / Tier 2 / Tier 3 $10 / $40 / $70	Not Covered
Mail Order Co-Pay	$20 / $80 / $140	Not Covered

The Buy-Up plan is offered for those who are looking for higher benefits. This plan has lower deductibles and lower out-of-pocket expenses. There is a higher cost to this plan and if elected you will pay the difference between the cost of the Base plan and the Buy-Up option.

Base Plan Employee Monthly Contribution

Type of Coverage	District Paid	District Dependent Contribution	Employee Contribution
Employee Only	**$635.00**	**n/a**	**$0**
Employee & Spouse	**$635.00**	**$120.00**	**$460.00**
Employee & Children	**$635.00**	**$110.00**	**$255.00**
Employee & Family	**$635.00**	**$180.00**	**$760.00**

Buy-Up Plan Employee Monthly Contribution

Type of Coverage	District Paid	District Dependent Contribution	Employee Contribution
Employee Only	**$635.00**	**n/a**	**$115.00**
Employee & Spouse	**$635.00**	**$120.00**	**$745.00**
Employee & Children	**$635.00**	**$110.00**	**$495.00**
Employee & Family	**$635.00**	**$180.00**	**$1,185.00**

You will receive a monthly benefit allotment of $635 from which your medical cost will be deducted. If you choose to "waive" the medical coverage, you will receive a monthly opt out allocation of $150. In order to receive this allocation, you must return the "waiver form" to the Business Office. This form is available on the Benefit Allocation page on the website.

Qualified High Deductible Health Plan with Health Savings Account

QUALIFIED HIGH DEDUCTIBLE HEALTH PLAN WITH HSA

Benefit/Service	In Network	Non-Network
Deductible	$3,000 / Individual $6,000 / Family	$6,000/ Individual $12,000 / Family
Coinsurance	90%	70%
Out-of-Pocket Maximum	$4,000 / Individual $8,000 / Family	$9,000 / Individual $15,000 / Family
Office Visit	Deductible	70% After Deductible
Preventive Care	100% Covered	70% After Deductible
Inpatient/Outpatient Hospital Services	90% After Deductible	70% After Deductible
Urgent Care	90% After Deductible	70% After Deductible
Emergency Room	90% After Deductible	70% After Deductible
Prescription Co-Pay	Tier 1 / Tier 2 / Tier 3 Deductible then 90%	Not Covered
Mail Order Co-Pay	Deductible then 90%	Not Covered

If you elect to enroll in the Qualified High Deductible Health Plan (QHDHP) you are required to enroll in the Health Savings Account. (HSA). The District requires $125 per month from the benefit allocation to be deposited in your HSA account.

If you are enrolling in the HSA for the first time, you must complete the Anthem Benefit Wallet HSA enrollment form. This form will be found in the online enrollment process. Your account cannot be set up until these forms are signed and returned to Barb Daves in the Business Office.

IRS rules dictate calendar maximum deposits into HSAs. The maximum amount includes the District's contribution plus any additional deposits you elect to add to your account. You cannot exceed these set maximums.

Since the District contributes $1,500 a year into your account, the employee maximum contribution levels for 2018 are $1,950 for Single and $5,400 for Family coverage. You may not put more than this amount in the account; you may put less. Individuals who are age 55 or older can also contribute an additional $1,000 in catch up contributions per year.

If you elect the QHDHP you may participate in the HSA.

The single deductible applies to the family deductible. Once the single deductible has been satisfied, benefits for that member are payable subject to coinsurance. Once the family deductible has been satisfied, benefits for the family will be payable subject to coinsurance.

QHDHP Employee Monthly Contribution				
Type of Coverage	**District Paid Premium**	**District Dependent Contribution**	**District Paid HSA Contribution**	**Employee Contribution**
Employee	**$510.00**	**n/a**	**$125.00**	**$0**
Employee & Spouse	**$875.00**	**$120.00**	**$125.00**	**$245.00**
Employee & Child(ren)	**$725.00**	**$110.00**	**$125.00**	**$105.00**
Employee & Family	**$1,195.00**	**$180.00**	**$125.00**	**$505.00**

Get the most out of your insurance by using

HEALTH SAVINGS ACCOUNT (HSA)

Facts about the HSA:

What is an HSA?

A savings account set up by either you or your company where you can either direct pre-tax payroll deductions or deposit money to be used by you to pay for current or future medical expenses for you and/or your dependents. Once money goes into the account, it's yours forever—the HSA is in your name, just like a personal banking account.

Why would I want an HSA?

Because you fund the HSA with pre-tax money, you are using tax-free funds for healthcare expenses you would normally pay for out-of-pocket using after-tax dollars. Your HSA contributions DO NOT count toward your taxable income for federal taxes.

What rules must I follow?

- You must be covered under a Qualified High Deductible Health Plan (QHDHP) in order to establish an HSA.
- You cannot establish an HSA if you also have a medical flexible spending account (FSA).
- You cannot set up an HSA if you have insurance coverage under another plan, for example your spouses' employer, unless that secondary coverage is also a QHDHP.
- You cannot be eligible for Medicare or Tricare.
- You cannot be claimed as a dependent under someone else's tax return.

What is the difference between Qualified High Deductible Health Plan and a Traditional PPO Plan?

In a QHDHP, all services received, with the exception of preventive care, are applied to the deductible first. This would include office visits and procedures that are not codes as preventive, emergency room visits, and prescription drugs. You will, however, still benefit from the discounts associated with using an in-network physician or facility.

What else do I need to know?

- Contributions are based on a calendar year. For 2018, the District will contribute $1,500 a year into your account. The employee contribution levels for 2018 are $1,950 for Single and $5,400 for Family coverage. You may not put more than this amount in the account, but you may put less. Individuals who are age 55 or older can also contribute an additional $1,000 in catch up contributions per year.
- The contributions from your paycheck are tax-free, grow tax-free, and come out tax-free as long as you utilize the funds for approved services (medical, dental, and vision).
- Your unused contributions roll over from year to year and can be taken with you if you leave your current job.
- If you use the money for non-qualified expenses, the money becomes taxable and is subject to a 20% excise tax penalty (like an IRA account).
- Once you turn 65, become disabled and/or qualify for Medicare you can use the account for other purposes without paying the 20% penalty. Taxes would, however, still apply.

Another advantage is that your account can grow over time.

Since the money always belongs to you, even if you leave the District, any unused funds carry over from year to year, so you never have to worry about losing your money. That means if you don't utilize a lot of healthcare services now, your HSA funds will be there if you need them in the future - even after retirement.

The HSA is also an investment opportunity

With an HSA, your account can grow tax-free in an interest-bearing savings account, a money market account, a wide variety of mutual funds - or all three. Of course, your funds are always available if you need them for qualified healthcare expenses.

Generally, you can put enough in your HSA to cover most of your deductible.

The QHDHP helps you pay for healthcare AFTER you meet the deductible. The annual HSA contribution limit is based on IRS rules. In general, the total amount that goes in your account each year can't be more than the IRS annual contribution limit. If you are age 55 or older, you are allowed to make an extra $1,000 catch-up contribution each year.

You can spend only the money that is actually in your HSA.

If your healthcare expenses are more than your HSA balance, you need to pay the remaining cost another way, such as cash or personal check. You can request reimbursement after you have accumulated more money.

You can use your HSA for your spouse and dependents - even if they are not covered by your QHDHP.

You can use HSA funds for IRS-approved items such as…

- Doctor's office visits
- Dental services
- Eye exams, eyeglasses, contact lenses, contact solution, and laser surgery
- Hearing aids
- Orthodontia, dental cleanings, and fillings
- Prescription drugs
- Physical therapy, speech therapy, and chiropractic expenses

More information about approved items, plus additional details about the HSA, is available on the IRS Website at irs.gov.

Every time you use your HSA, save your receipt in case the IRS asks you to prove your claim was a qualified expense. The banking institution is required to report all withdrawals from your HSA. If you use HSA funds for a non-qualified expense, you will be responsible for the taxes on that amount plus a 20% penalty.

HSA Resources

Available resources on mybenefitwallet.com include:

- Modeling tools
- Frequently asked questions
- Educational materials
- Educational video library

Call the BenefitWallet Service Center at 1 877.472.4200

CARE OPTIONS AND WHEN TO USE THEM

Primary Care

For routine, primary/preventive care, or non-urgent treatment, we recommend going to your doctor's office for medical care. Your doctor knows you and your health history, and has access to your medical records. You may also pay the least amount out of pocket when you receive care in your doctor's office.

Convenience Care

Sometimes, you may not be able to get to your doctor's office, and your condition is not urgent or an emergency. In these situations, you may want to consider a convenience care center that can be an alternative to seeing your doctor.

Convenience care centers are conveniently located often in malls or some retail stores, such as CVS Caremark, Walgreens, Walmart and Target, and offer services without the need to schedule an appointment. Services at a convenience care center may be provided at a lower out of pocket cost than an urgent care center visit and are subject to primary care physician office visit copays and/or deductible/ coinsurance.

Typical conditions that may be treated at a convenience care center include:

- Common infections (e.g.: bronchitis, bladder infections, ear infections, pink eye, strep throat)
- Minor skin conditions (e.g.: athlete's foot, cold sores; minor sunburn, poison ivy)
- Flu shots
- Pregnancy tests

This is a sample list and not all-inclusive. For a full listing of services please visit each center's website.

Services at a convenience care center are generally available to patients 18 months of age or older. Services that are available may vary per center. We do, however, recommend that you seek routine medical care from your primary care physician whenever possible.

To find an in-network convenience care center near you, visit our website at anthem.com.

Urgent Care

Sometimes you may need medical care fast, but a trip to the emergency room may not be necessary. Of course, during office hours you may be able to go to your doctor for any urgently needed service; however, if you require urgent care outside your doctor's regular office hours or you are unable to be seen by your doctor immediately, you may consider going to an urgent care center. At an urgent care center, you can generally be treated for many minor medical problems faster than at an emergency room. We do however, recommend that you seek routine medical care from your primary care physician whenever possible.

Typical conditions that may be treated at a Urgent Care Center include:

- Sprains
- Strains
- Mild asthma attacks
- Minor infections
- Vaccinations
- Small cuts
- Sore throats
- Rashes
- Preventive Screenings
- Back Pain or Strains

This is a sample list and not all-inclusive. For a full listing of services please visit each center's website.

Services that are available for urgent care may vary per center. If you choose to use an urgent care center, please make sure it is in-network by calling the toll-free number on the back of your medical ID card or visiting the carrier's website at anthem.com.

Lab Services

If you require lab work consider having these services performed at Quest or Lab Corp. If you choose to use Quest or Lab Corp, services associated with the cost of your lab work will not apply to the deductible and coinsurance and will be covered 100% in most cases.

Emergency Room

Going to the emergency room or calling 911 is always the way to go when it's an emergency, but you will be responsible for emergency room costs when it isn't an emergency.

An emergency medical condition is any condition (including severe pain) which you believe that without immediate medical care may result in:

- Serious jeopardy to your or your loved one's health, including the health of a pregnant woman or her unborn child
- Serious impairment to you or your loved one's bodily functions

If you obtain care at an emergency room, you will likely pay more out of pocket than if you were treated at your doctor's office, a convenience care center or urgent care facility.

Anthem will cover non-emergency ER claims in the following circumstances:

- **ER services for children under the age of 14.**
- **If there isn't an urgent care center or retail health clinic within 15 miles of the member.**
- **If a member was directed to the emergency room by another medical provider.**
- **Any visit that occurs on a Sunday or major holiday.**

*If you receive treatment for an emergency in a non-network facility, you may be transferred to an in-network facility once the condition has been stabilized.

PRESCRIPTION BENEFITS

Most prescriptions are filled right away when you take them to the pharmacy. However, some drugs need to be reviewed by Anthem and approved before they're covered. This process, called ***prior authorization***, helps ensure drugs are used as recommended by the FDA. Prior authorization focuses mainly on drugs that may have:

- Risk of serious side effects or dangerous drug interactions
- High potential for incorrect use or abuse
- Better alternatives that may cost you less
- Restrictions for use with very specific conditions

Prior authorization may require you to take an additional step when you are prescribed certain medications, but the long-term gain is lower out-of-pocket prescription costs for you and reduced claims expense for the School District of Clayton and potentially lower future renewal increases.

Some prescription drugs are covered only if the physician obtains prior authorization from Anthem. In addition, coverage for some drugs is provided in limited quantities and duration.

This is only a brief summary of benefits. The certificate, issued when coverage is approved for the group, contains program details, and will, in all cases, have control over any information in this summary. The certificate is available upon request.

PREVENTIVE CARE

Certain preventive services will be covered without charging a deductible, copayment, or coinsurance when these services are provided by a **network provider**. The types of preventive services covered are defined by federal law and can vary based on your age, gender, and health status. There may be services you had in the past that will now be covered as preventive at no cost to you. The preventive services included in this provision are described at healthcare.gov.

School District of Clayton

DENTAL - METLIFE (PPO)

Dental - PPO

One option is a PPO plan with MetLife. This option offers you more freedom to choose any dentist. The allotment covers the employee cost of the MetLife PPO plan.

Benefits	MetLife PPO	Non-Network
Deductible Individual Family	 $50 $150	 $50 $150
Coinsurance		
Diagnostic/Preventive • Oral Exam - 2 every 12 months • Cleaning - 2 every 12 months • Bitewing X-rays - 2 sets every 12 months • Full Mouth X-ray - Once every 36 months • Topical Fluoride - Child under age 16 • Space Maintainers - Child under age 16	0% Deductible is Waived	0% Deductible is Waived
Basic Services • Sealants - Child under age 16 • Amalgam and Resin Fillings • Simple and Surgical Extractions • Root Canals - Once every 24 months for same tooth • Periodontal Treatment and Surgical Treatment - Limits Apply	10% Deductible Applies	20% Deductible Applies
Major Services • General Anesthesia • Oral Surgery • Dentures • Crowns • Implants	40% Deductible Applies	50% Deductible Applies
Orthodontia • Child up to age 19	50% Deductible Does Not Apply	50% Deductible Does Not Apply
	Fee Schedule	90th Percentile
Annual Maximum Benefit	$1,500/person	
Ortho Lifetime Max.	$1,000/child	

Plan Highlights

- You do not need an ID card. Your dentist can confirm your eligibility by contacting MetLife.
- If you believe your dental procedure will exceed $300, have your dentist contact MetLife for an estimate.
- Is your dentist a non-network dentist? Benefits will be paid at the 90th percentile, which means what 9 out of 10 dentists charge in area where your dentist is located. This could cause you to have higher out-of-pocket expenses.

MetLife PPO Employee Contribution

Type of Coverage	District Paid Premium	Employee Contribution
Employee	$44.65	$0
Employee & Spouse	$44.65	$44.67
Employee & Child(ren)	$44.65	$57.40
Employee & Family	$44.65	$102.55

DENTAL - CIGNA (DHMO)

Following is a sample schedule of the CIGNA DHMO patient charge schedule:

Plan Highlights

- You are responsible for a $5 Office Visit Fee per patient, per office visit.
- You have to be on the dentist's roster in order to receive treatment.
- Check the Patient Charge Schedule K1-V9 before receiving services to know your responsibility.
- The Patient Charge Schedule K1-V9 is located in Custom Solutions or you can contact Barb Daves in the Business Office for a copy.
- If a procedure is not shown in the schedule, it is not covered.

CODE	PROCEDURE	PATIENT PAYS
D1110	Adult Cleaning	No Charge
D0270	Bitewings	No Charge
D0330	Panoramic X-Ray	No Charge
D2330	Composite - Surface	No Charge
D2140	Amalgam - 1 surface	No Charge
D2752	Crown - Porcelain	$425
D6794	Crown - Titanium	$460
D3310	Root Canal - Anterior	$210
D3320	Root Canal - Bicuspid	$245
D3330	Root Canal - Molar	$335
D4210	Gingivectomy 4 per Quad	$180
D5110	Full Upper Denture	$625
D5120	Full Lower Denture	$625
D6065	Implant supported porcelain/ceramic crown	$790
Ortho	24-Month Treatment Fee	$2,040

You will receive a monthly benefit allotment of $44.65 from which your dental plan cost will be deducted.

Cigna DHMO Employee Contribution

Type of Coverage	District Paid Premium	Employee Contribution	Allotment Balance
Employee	$26.67	$0	($17.98)
Employee & Spouse	$46.74	$2.09	$0
Employee & Child(ren)	$49.46	$4.81	$0
Employee & Family	$74.96	$30.31	$0

School District of Clayton

VISION - VISION BENEFITS OF AMERICA (VBA)

Benefit/Service	In Network	Non-Network
Exam Co-pay	0%	$35
Frequency		
Exam	Every 12 months	
Lenses	Every 12 months	
Frames	Every 24 months	
Lenses	$5 Co-pay then	Reimbursed up to:
Single	0%	$35
Bifocal	0%	$45
Trifocal	0%	$60
Frames	0% $50 Wholesale $125 to $150 Retail	Reimbursed up to: $35
Contacts		Reimbursed up to:
Medically Necessary	UCR*	$250
Cosmetic	$130 (Allowance)	$130 (Allowance)

NOTE: Contact allowance shown is applied to all services/materials associated with the contact lenses. This includes exam, fitting, dispensing, lenses, etc.

* UCR refers to Usual Customary and Reasonable charges. To determine the UCR, Vision Benefits of America takes the procedural charge of area providers and calculates an average. Charges above this average become your responsibility.

PLAN HIGHLIGHTS

- If you visit one of VBA's providers you do not have to obtain a voucher. Your vision provider can receive your benefits electronically.
- Non-Network benefits are based on a reimbursement schedule.
- You are eligible for savings on Lasik vision services. Savings range from 40% to 50% off the national average price of traditional Lasik.
- You MUST contact QualSight to obtain Lasik services. Phone number is (877) 437-6105.

Vision Employee Monthly Contribution

Type of Coverage	District Paid Premium	Employee Contribution
Employee	$4.42	$0
Employee & Spouse	$4.42	$7.12
Employee & Children	$4.42	$5.25
Employee & Family	$4.42	$13.57

You will receive a monthly benefit allotment of $4.42 from which your vision plan cost will be deducted.

BASE LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT

This benefit is paid by the School District of Clayton for all eligible employees. It is administered through MetLife. In the event of your death, your beneficiary will receive $50,000. The Accidental Death and Dismemberment (AD&D) benefit is equal to your basic group life insurance benefit in the case of death. AD&D benefits for accidental dismemberments are proportionate and are described in the certificate of coverage.

VOLUNTARY LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT

MetLife offers employees the opportunity to purchase additional life insurance for you, your spouse, and eligible children. If you are currently enrolled in the voluntary life plan, you may increase your current coverage by $10,000 without submitting evidence of insurability as long as the new elected coverage does not exceed the guaranteed issue amount. Coverage for your spouse can be increased by $5,000 without submitting evidence of insurability as long as it does not exceed the guaranteed issue amount or 50% of your elected coverage. If you are not currently enrolled, any elected coverage requires completion of the evidence of insurability form. Coverage will go into effect once MetLife approves your application.

Monthly Cost	
Age Band	**Rate per $1,000**
Under 30	**$.033**
30-34	**$.038**
35-39	**$.049**
40-44	**$.073**
45-49	**$.115**
50-54	**$.180**
55-59	**$.275**
60-64	**$.388**
65-69	**$.691**
70+	**$1.149**
Child	**$.240 Per $1,000 of Coverage.**

EMPLOYEE COVERAGE

Employees may elect coverage in increments of $10,000 up to the lesser of $500,000 or 5 times your salary. Guaranteed Issue: $200,000

SPOUSE COVERAGE

Spousal coverage is available in $5,000 increments not to exceed 50% of the employee amount up to a maximum of $200,000. Spouse rates are based upon the employee's age. Guaranteed Issue: $25,000

CHILDREN

Coverage is available for your children up to age 26 whether or not they are a full-time student. You can elect coverage of $10,000. The amount you select is for each child you cover. The cost is based upon the family unit and not each child. Guarantee issue does not apply to child coverage.

Our Voluntary Life plan also offers you the opportunity to purchase Voluntary Accidental Death & Dismemberment (AD&D). The AD&D is available for employee, spouse, and eligible child(ren) coverage. The Voluntary AD&D is optional; however, if you elect this coverage, the amount of coverage must match your elected Voluntary Life coverage. Example: If you elect $100,000 of Voluntary Life Insurance, your elected Voluntary AD&D coverage must also be $100,000.

Rate per $1,000 of Coverage	
Single	**$.017**
Spouse	**$.017**
Child(ren)	**$.049**

HOW TO CALCULATE VOLUNTARY PREMIUM

$5,000 (Elected Coverage) ÷ 1,000 = 50 (Units) X $0.115 (Rate * See Note) = $5.75 (Monthly Cost)

*The premium calculation is based upon the life rate for an employee age 45.

VALUE ADDED BENEFIT - WILL PREPARATION ASSISTANCE

By enrolling for voluntary term life insurance, you will have in-person access to Hyatt Legal Plans' (1-800-821-6400) network of 11,500 participating attorneys for preparing or updating a will, living will and power of attorney. When you enroll in this plan, you may take advantage of this benefit at no additional cost to you if you use a participating plan attorney.

School District of Clayton

LONG-TERM DISABILITY INSURANCE

The School District of Clayton provides you with Long-Term Disability (LTD) protection. This benefit protects your income to age 65 if you are totally disabled. Following are some key components of the plan:

- 180 day waiting period before benefits begin.
- 66 2/3% salary reimbursement to $5,000 per month maximum.
- Benefits are payable for 3 years if you are unable to perform your occupation. Benefits are available to age 65 if your are totally disabled and unable to perform any occupation.

LONG-TERM CARE

Long-Term Care is defined as the type of care received either at home or in a facility when someone needs assistance with activities of daily living, or suffers severe cognitive impairment due to an accident, an illness, or advancing age. Health insurance will not cover the cost of nursing home stays, and government programs like Medicare and Medicaid often fall short as well. This is why the School District of Clayton offers employees and their spouses the opportunity to purchase long- term care insurance at a group rate through UNUM.

All newly hired employees will have 30 days to sign up for the guaranteed issue coverage. Completion of a benefit election form is required for enrollment. If you choose an amount or duration beyond the guaranteed issue, a medical questionnaire will also be required. All spouses must complete the benefit election form as well as a medical questionnaire. If you elect to purchase the long-term care coverage after your initial 30 day period, all elected coverage will require evidence of insurability. Please contact Barb Daves in the Business Office for a packet of information, cost, and enrollment forms.

Benefit Duration	3 Years	6 Years	Unlimited Duration
Facility Benefit Amount per $1,000 Increments	$2,000 to $6,000	$2,000 to $6,000	$2,000 to $6,000
Residential Care Facility II	60%	60%	60%
Lifetime Maximum Per $1,000 Increments	$36,000	$72,000	Unlimited
Professional Home Care	50%	50%	50%
Total Home Care - **Option**	50%	50%	50%
Inflation Protection* - **Option**	Simple Capped	Simple Capped	Simple Capped

**If you selected an inflation option, and you terminate that inflation option at a future date, you can purchase the inflated coverage amount at your original age.*

WORKSITE BENEFIT PROGRAM

The School District of Clayton offers you supplemental insurance from UNUM as an addition to your existing benefit package. Two benefit options are offered to you on a voluntary basis. You decide whether or not to purchase these benefits. These benefit plans are offered only during our annual open enrollment process. You will be provided a website to enroll. If you elect either of these two worksite benefit programs, premiums will be deducted from your paycheck. Both of these plans are portable if you leave the District.

ACCIDENT EXPENSE BENEFIT

This plan helps offset unexpected medical expenses that result from on or off the job accident related expenses such as deductibles, co-pays, travel expenses, etc. Benefits are tax free and paid directly to you. There is a hospital confinement for sickness rider available for an additional cost. This rider pays you $200 per day if confined to a hospital.

CRITICAL ILLNESS

This benefit provides a tax-free lump sum benefit for diagnosis of one of the following: Cancer, Heart Attack, Stroke, Permanent Paralysis, Kidney Failure, Major Organ Failure, and Coronary Artery Bypass Surgery. Benefit amount is based upon diagnosis and can be up to $50,000. It also pays an annual $75 Wellness Benefit for health screening tests.

EMPLOYEE ASSISTANCE PROGRAM (EAP)

Through our EAP contract with our service provider, Personal Assistance Services (PAS), you and your eligible dependents can receive confidential assistance with personal and work/life concerns.

The EAP provides short-term, confidential counseling in dealing with family and relationship issues, substance abuse, stress and anxiety, communication issues, and emotional concerns. The EAP also provides the following services to help you balance work and home life:

- Marital/relationship concerns
- Parenting challenges
- Financial planning
- Budget/debt problems
- Identity theft
- Job stress
- Legal concerns
- Child care resources and referral
- Education and college planning
- Elder care planning and management
- Emotional health and wellness
- Substance abuse
- Tobacco cessation
- Healthy eating and exercise
- Household management
- Coping with a chronic health condition
- Career planning
- Organization and time management

PAS specializes in providing professional counseling services through highly qualified, licensed behavioral health practitioners. PAS professionals answer calls 24 hours a day, seven days a week. PAS telephone number is 314-842-6223 or 1-800-356-0845. When you call PAS a representative will answer any questions you have and set up an appointment for you. Please visit the PAS website for additional information at **paseap.com**.

School District of Clayton

FLEXIBLE SPENDING ACCOUNTS

TYPES OF ACCOUNTS

SECTION 125 MEDICAL SPENDING ACCOUNT: This account enables you to pay with pre-tax dollars any medical, dental, vision, and prescription drug expenses that are not covered under your insurance program or that of your spouse. You may also cover dependent health care expenses through the account even if you choose single coverage. The total amount of your annual pledge is available to you up front thus reducing the risk of a large out-of-pocket expense at any one time during the plan year. Be aware that with the Section 125 Medical Account, any unused portion of the account at the end of the plan year is forfeited. You cannot establish the FSA if you also contribute to a Health Savings Account (HSA).

DEPENDENT CARE EXPENSE ACCOUNT: This account gives you the opportunity to redirect a portion of your annual pay on a pre-tax basis to pay for dependent care expenses. An eligible dependent is any member of your household for whom you can claim expenses on your Federal Income Tax Form 2441, "Credit for Child and Dependent Care Expenses." Children must be under age 13. Care centers which qualify include dependent care centers, preschool educational institutions, and individuals, as long as the caregiver is not a child of yours under age 19 or anyone you can claim as a dependent for tax purposes. Before deciding to use the Dependent Care Expense Account, it would be wise to compare its tax benefit to that of claiming a child care tax credit when filing your tax return. Either may be better, depending on your personal situation. You may not use both. You may want to check with your tax advisor to determine which method is best for you and your family. Any unused portion of your account balance at the end of the plan year is forfeited.

Maximum Contributions	
Section 125 Medical Account	$2,650 max
Dependent Care Expense Account	$5,000 max

ACCOUNT STATEMENTS

You may request a full statement of your accounts at any time by calling or sending a written request to CBIZ. You can also manage your account by logging onto myplans.cbiz.com to view account balances, view the expenses that have been paid, and see any other account information.

HOW THE ACCOUNT WORKS

When you have eligible expenses not covered under the health insurance plan, such as co-payments and deductibles, you can utilize your CBIZ FSA Debit Card for payment from your Section 125 Medical Account. You may also submit a FSA claim form with your receipt and a reimbursement payment will be issued to you directly.

When you have dependent care expenses, you may complete a dependent care claim form and submit it to CBIZ with a receipt from your child care provider. A reimbursement payment is issued to you directly. Please note, the receipt for your child care provider must include the name, address, and federal tax identification number or social security number of the provider.

You can submit claims through the website at:

myplans.cbiz.com

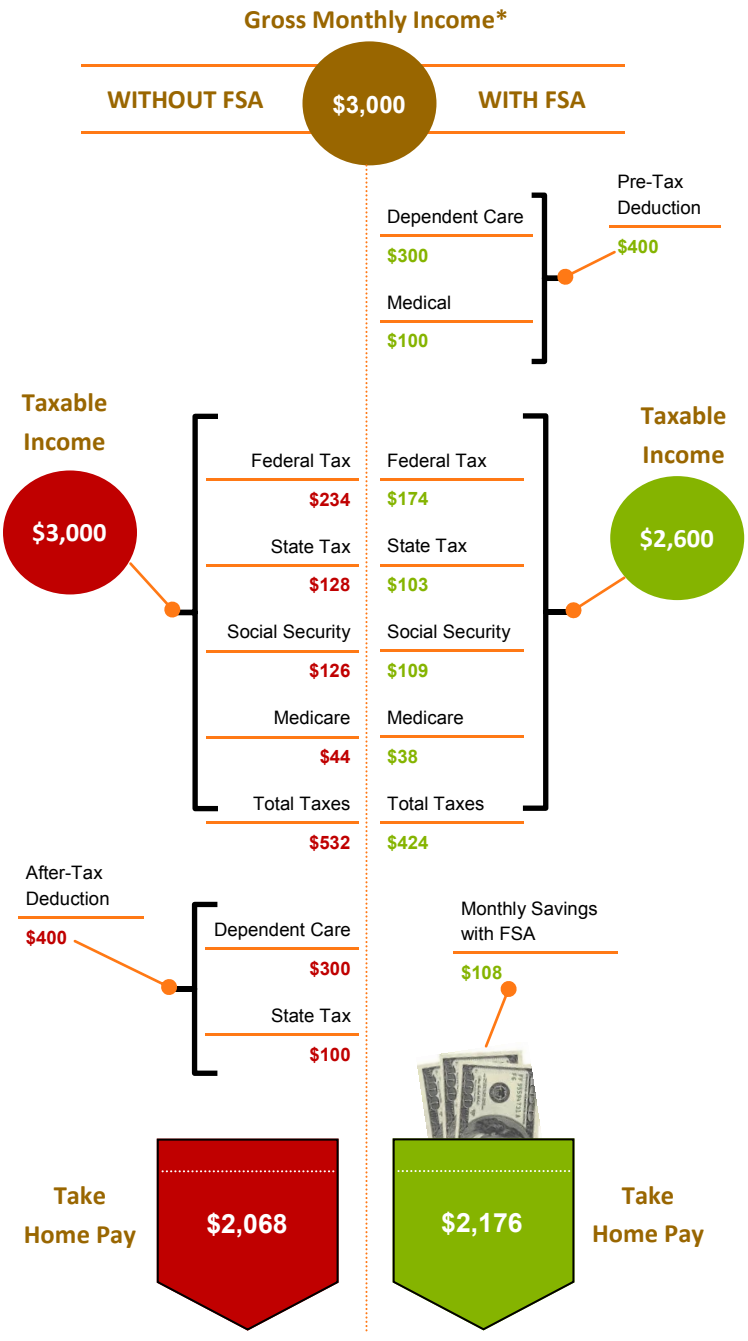
OR you can submit claims by sending a claim to:

CBIZ Flex
2797 Frontage Road
Roanoke, VA 24017

REIMBURSEMENT PROCEDURE

All FSA claim reimbursements will be made through direct deposit into your bank account. If you elect to participate in the FSA you are REQUIRED to complete the direct deposit form found in Custom Solutions. Reimbursements will NOT be made by check.

How will a flexible spending arrangement save you money?



* This is an example and for illustration purposes only. Taxes are not exact and will vary.

Below is a partial list of eligible expenses that can be reimbursed from a Section 125 Medical Account. Other

Alcoholism treatment	Laboratory fees
Artificial limbs	Licensed osteopaths
Ambulance	Licensed practical nurses
Braces	Orthodontia
Chiropractors	Orthopedic shoes
Coinsurance and	Obstetrical expenses
Contact lens solution	Oxygen
Contraceptives	Prescription drugs
Crutches	Podiatrists
Deductible amounts	Prescribed vitamin supplements
Dental expenses	Psychiatric care
Dentures	Psychologist expenses
Dermatologists	Routine physical
Diagnostic expenses	Seeing-eye dog expenses
Eyeglasses, including	Smoking cessation pro-grams
Handicapped care and support	Sterilization and reversals
Nutrition counseling	Substance abuse
Hearing devices and	Surgical expenses
Hospital bills	

IMPORTANT BENEFIT INFORMATION

PRE-TAX PREMIUM CONTRIBUTIONS

It is important to remember that all contributions for medical, dental, and vision premiums are paid on a pre-tax basis according to Section 125 of the IRS code. This means premiums will be deducted from your gross income. Taxes will then be applied to the remaining payroll amount.

BENEFIT ALLOTMENT

The District covers all of the "Employee Only" cost of the Base PPO Medical, MetLife PPO Dental, and Vision plans. The benefit allotment designated for January 1, 2018 through December 31, 2018 is $8,208.84 or $684.07 per month.

- Unused benefit allocation funds will be distributed over the course of the plan year on each pay date as taxable income.
- If you participate in the Health Savings Account, the District provided HSA contribution will be $125 per month. This $125 per month will be deducted from the allotment.

STIPEND IN LIEU OF BENEFITS

The District offers an $1,800 annual stipend to any employee who is eligible for insurance benefits, waives the medical coverage, and can prove they are covered elsewhere under another medical plan. The $1,800 stipend is equally divided by the number of pay dates in the plan year (January 1 to December 31) and the pro-rated amount is included in your paycheck. Employees who become eligible for the stipend at any time during the plan year due to a qualifying event or as a new hire, will receive only the pro-rated amount.

- The stipend will be paid as taxable income.
- A signed waiver is required along with proof of coverage.

This is an annual election. Your signed waiver and proof of coverage is required every year. The waiver form can be found and printed from the Custom Solutions enrollment site.

Send your completed waiver form along with proof of current coverage to Barb Daves, ext. 6024. A copy of your current medical identification card is acceptable as proof of current coverage.

DEPENDENT ELIGIBILITY AUDIT

In 2014 The School District of Clayton performed an eligibility audit. The audit required all employees who elected to cover their dependents under their employee benefit plans to provide specific documentation showing the dependent's eligibility.

As an ongoing process to identify eligible dependents, all new employees and any current employee who adds dependent coverage will be asked to provide the required documentation. The District will also choose, on a random basis, employee's with current dependent coverage to again show documentation of eligibility.

SICK LEAVE, VACATION TIME, OTHER BENEFITS

You can access additional employee benefit information by going to the District's home page and linking to Staff, Human Resources, Employee Resources, Leave Guidelines.

IMPORTANT NOTICES

Special Enrollment Notice

During the open enrollment period, eligible employees are given the opportunity to enroll themselves and dependents into our group health plans. If you elect to decline coverage because you are covered under an individual health plan or a group health plan through your parent's or spouse's employer, you may be able to enroll yourself and your dependents in this plan if you and/or your dependents lose eligibility for that other coverage. If coverage is lost, you must request enrollment within 30 days after the other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may enroll any new dependent within 30 days of the event. To request special enrollment or obtain more information, contact Barb Daves at extension 6024.

Notice of Material Change (also Material Reduction in Benefits)

The School District of Clayton has amended The School District of Clayton's Health Benefits Plan. This benefit guide contains a summary of the modifications that were made. It should be read in conjunction with the Summary Plan Description or Certificate of Coverage, which is available to you once it has been updated by the carriers. If you need a copy, please submit your request to Barb Daves in the District Office of Business and Finance.

Women's Health and Cancer Rights Act of 1998

As a requirement of the Women's Health and Cancer Rights Act of 1998, your plan provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema.

The benefits must be provided and are subject to the health plan's regular copays, deductibles, and co-insurance. You may contact our health carrier at the phone number on the back of your ID card for additional benefit information.

Notice of Privacy Practices

The School District of Clayton is subject to the HIPAA privacy rules. In compliance with these rules, it maintains a Notice of Privacy Practices. You have the right to request a copy of the Notice of Privacy Practices by contacting The School District of Clayton's Human Resources Department.

Marketplace Options

HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE

General Information

When key parts of the health care law took effect in 2014, there was a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the Marketplace and employment-based health coverage offered by The School District of Clayton.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance which meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit which lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins November 1st through January 31st.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium. Savings depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer which offers minimum essential coverage and meets affordability standards, you will not be eligible for a tax credit through the Marketplace. If you purchase health coverage through the Marketplace, you may lose any employer contribution offered for the employer-offered coverage. Employer and employee contributions for employer-offered coverage are often excluded from Federal income tax. Payment for Marketplace coverage is made on an after-tax basis.

More Information

New employees will receive a notice of Marketplace Coverage Options advising the standards of offered coverage. Please visit HealthCare.gov for more Marketplace information.

Medicaid CHIP Notice

Premium Assistance under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're also eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, **healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed on the DOL website provided below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

Following is a link to the latest form and states where you may be eligible for assistance paying your employer health premiums: dol.gov/ebsa/pdf/chipmodelnotice.pdf

For more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
dol.gov/ebsa
1-866-444-3272
Menu Option 4, Ext 61565

U.S. Department of Health and Human Services
Centers for Medicare and Medicaid Services
cms.hhs.gov
1-877-267-2323

Medicare Part D Credible Coverage

This notice has information about your current prescription drug coverage and about your options under Medicare's prescription drug coverage. If you are eligible for Medicare the following information can help you decide whether or not you want to join a Medicare drug plan. You should consider comparing your current coverage through our medical plan with the costs of plans offering Medicare prescription drug coverage in

your area. Two important things you need to know about your current coverage and Medicare prescription drug coverage:

Medicare prescription drug coverage is available if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan. All Medicare drug plans provide at least a standard level of coverage set by Medicare. More coverage may be offered at a higher premium.

Anthem has determined that the prescription drug coverage offered by The School District of Clayton is on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pay and is therefore considered Creditable Coverage. Because this coverage is Creditable Coverage, you can keep it and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

If you lose your current creditable prescription drug coverage through no fault of your own, you will be eligible for a two-month Special Enrollment Period to join a Medicare drug plan.

If you decide to join a Medicare drug plan, your current coverage will not be affected. This plan will coordinate with Part D coverage. If you drop your current coverage, be aware that you and your dependents will be able to get this coverage back.

If you drop or lose your current coverage and don't join a Medicare drug plan within 63 continuous days after your coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

This information is provided for the Medicare open enrollment period which begins on October 15. If you want more information about Medicare plans that offer prescription drug coverage, you will find it in the Medicare & You handbook or you can visit medicare.gov or call 1-800-MEDICARE (1-800-633-4227) TTY users: 1-800-486-2048. If you have limited income and resources, visit Social Security on their website at socialsecurity.gov, or call them at 1-800-772-1213. TTY users: 1-800-325-0778.

Keep all Creditable Coverage notices. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of the notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

ARE THERE OPTIONS TO COBRA? THE ANSWER IS, YES.

When you are eligible for employee benefits you and your covered dependents receive an initial COBRA notification which advises you of COBRA rights. This notification explains your rights under COBRA and what you must do to in case you or a covered dependent experiences a qualifying event. You should file this notification for easy access as it includes rules you have to follow.

If a COBRA event is experienced, you may ask what other options are available. COBRA is made available to continue your coverage with no interruption for a specific timeframe, however, there are options available through the ACA Marketplace (Exchange) you may want to consider. You may receive assistance with your COBRA options by contacting SelectQuote Benefit Solutions.

HOW TO START YOUR RESEARCH:

- Go To: **cbiz.sqbenefits.com**. OR
- Call SelectQuote at 1.855.801.5742 to receive assistance.

CONSIDERATIONS ARE:

- Cost of coverage. COBRA may be more expensive than a new policy offered through the healthcare exchange.

- Low income individuals may be eligible for a federal subsidy.
- The benefits offered by COBRA vs an ACA exchange.
  - Which plan offers the coverage you need?
  - Is your provider in the network?

IF YOU RETIRE FROM THE SCHOOL DISTRICT OF CLAYTON, ARE THERE OPTIONS AVAILABLE BESIDES THE RETIREE BENEFITS THE ANSWER IS, YES.

If you are eligible and retire through PSRS/PEERS from the School District of Clayton you are offered Medical, Dental, and Vision benefits. These benefit options are offered to retirees at the current cost charged by the carriers.

As a retiree, you may ask yourself if there are other options which offer plans closer to your needs with cost options. The answer is found through SelectQuote Benefit Solutions, which offers free comparison shopping for your insurance needs.

HOW TO ACCESS ASSISTANCE WITH RETIREE OPTIONS:

- Website: **cbiz.sqbenefits.com**
- Select Your Benefit: Medicare (Post 65) OR Healthcare (Pre 65)
- You can speak with a representative by calling 1.855.801.5742
- You can Request a Free Quote

WHAT IS AVAILABLE:

Resource Center - Locate all educational videos and documents

- Understanding Medicare
- What is an insurance exchange.
- How a Medicare exchange works.
- How Getinsured is working for you.
- Retiree Handouts
  - Retiree Healthcare Planning
  - Cobra vs Alternatives
  - Health Matters for Medicare
  - Health Matters for Healthcare

Get a Free Quote...

A free quote is available to all CBIZ VIP customers, family, and friends. If you fill in a request for a free quote a representative will call you.

Important Information Regarding 1095 Forms

As an employer with 50 or more eligible employees the District is required to provide 1095-C forms to all employees who were eligible for coverage under our group health plan in 2017. If you were eligible for coverage under our group plan you will receive a personalized 1095-C form in January 2018. We are also required to send a copy of your 1095-C form to the IRS.

The information reported on Form 1095-C is used in determining whether an employer owes a payment under the employer shared responsibility provisions under section 4980H. Form 1095-C is also used by the IRS and the employee in determining the eligibility of the employee for the premium tax credit.

If eligible, you'll need the 1095-C form to complete your annual Federal tax return.

GLOSSARY OF TERMS

Coinsurance – Your share of the cost of covered services which is calculated as a percentage of the allowed amount. This percentage is applied after the deductible has been met. The plan pays any remaining percentage of the cost until the out-of-pocket maximum is met. Coinsurance percentages will be different between in-network and non-network services.

Copays – A fixed amount you pay for a covered health care service. Copays can apply to office visits, urgent care, or emergency room services. Copays will not satisfy any part of the deductible. Copays should not apply to any preventive services.

Deductible – The amount of money you pay before services are covered. Services subject to the deductible will not be covered until it has been fully met. It does not apply to any preventive services as required under the Affordable Care Act.

Emergency Room – Services you receive from a hospital for any serious condition requiring immediate care.

Lifetime Benefit Maximum – All plans are required to have an unlimited lifetime maximum.

Medically Necessary – Health care services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease or its symptoms, which meet accepted standards of medicine.

Network Provider - A provider who has a contract with your health insurer or plan to provide services at set fees. These contracted fees are usually lower than the provider's normal fees for services

Out-of-Pocket Maximum – The most you will pay during a set period of time before your health insurance begins to pay 100% of the allowed amount. The deductible, coinsurance, co-pays, and prescription drug co-pays are included in the out-of-pocket maximum.

Preauthorization – A process by your health insurer or plan to determine if any service, treatment plan, prescription drug, or durable medical equipment is medically necessary. This is sometimes called prior authorization, prior approval, or precertification.

Preferred Provider – A provider who has a contract with your health insurer or plan to provide services at set fees. These contracted fees are usually lower than the provider's normal fees for services.

Prescription Drugs – Each plan offers its own unique prescription drug program. Specific copays apply to each tier and a medical plan can have one to five separate tiers. The retail pharmacy benefit offers a 30-day supply. Mail Order prescriptions provide up to a 90-day supply. Sometimes the deductible must be satisfied before copays are applied.

Preventive Services – All services coded as Preventive must be covered 100% without a deductible, coinsurance, or copayments.

UCR (Usual, Customary and Reasonable) – The amount paid for medical services in a geographic area based on what providers in the area usually charge for the same or similar service.

Urgent Care – Care for an illness, injury or condition serious enough that a reasonable person would seek immediate care, but not so severe to require emergency room care.